(3) Admissions Involving One-Day Length of Stay Following Surgical Services

If a patient who requires hospital inpatient services, is admitted for a one-day stay following outpatient surgery, the hospital shall be paid at the transfer per diem rate instead of the hospital-specific SPAD.

(4) Transfer between a Distinct Part Psychiatric Unit and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a distinct part psychiatric unit and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, MH/SAP network or non-network hospital, or the type of service provided. Please refer to the appropriate matrix in **Exhibit 3** for reimbursement under specific transfer circumstances involving psychiatric stays.

(5) Change of Managed Care Status during a Psychiatric or Substance Abuse Hospitalization

(a) Payments to hospitals <u>without</u> network provider agreements with the Division's MH/SAP MCO

When a recipient becomes assigned to the MH/SAP during a non-emergency or emergency mental health or substance abuse admission at a Non-Network Hospital, the portion of the hospital stay during which the recipient was assigned to the MH/SAP shall be paid by the Division's MH/SAP MCO. The portion of the hospital stay during which the recipient was not assigned to the MH/SAP will be paid by the Division at the psychiatric per diem rate for mental health services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

(b) **Payments to hospitals with network provider agreements with the Division's MH/SA Provider.**

When a patient becomes assigned to the MH/SAP during an emergency or non-emergency mental health or substance abuse hospital admission, the portion of the hospital stay during which the recipient was assigned to MH/SAP shall be paid by the Division's MCO at the per diem rates agreed upon by the hospital and the MCO.

The portion of the hospital stay during which the recipient was not assigned to MH/SAP will be paid by the Division at the psychiatric per diem for mental health services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

10. Physician Payment

For physician services provided by hospital-based physicians to Medicaid inpatients, the hospital will be reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 et seq. (attached as Exhibit 4). Such reimbursement shall be at the lower of the fee in the most current promulgation of the DHCFP fees as established in 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00 (Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)[1], or the hospital's usual and customary charge.

Hospitals will be reimbursed for such physician services only if the hospital-based physician took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the DME portion of the SPAD payment and, as such, are not reimbursable separately. Hospitals will not be reimbursed separately from the SPAD and per diem payments for professional fees for practitioners other than hospital-based physicians.

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[1] These regulations are voluminous, and will be provided upon request.

Hospitals shall not be reimbursed for inpatient physician services provided by community-based physicians.

11. **Payments for Administrative Days**

Payments for administrative days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals.

- The AD rate is comprised of a base per diem payment and an ancillary add-on.

- The base per diem payment is the average Medicaid nursing home rate in state fiscal year 1995 for acuity categories H to L. This base rate is $75.83. The ancillary add-on ratios of 0.0665 and 0.2969, for Medicare/Medicaid Part B eligible patients and Medicaid-only patients, respectively, were maintained for the RY98 RFA. The resulting AD rates (base and ancillary) were then updated for inflation using the update factors 3.16% for RY96; 2.38% for RY97; and 2.14% for RY98. The resulting AD rates for RY98 are $82.60 for Medicare/Medicaid Part B eligible patients and $133.22 for Medicaid-only eligible recipients.

A hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD where the patient fluctuates between acute status and AD status; the hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for outlier days, as described above.

12. **Infant and Pediatric Outlier Payment Adjustments**

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to acute hospitals for inpatient hospital services furnished to infants under one year of age

involving exceptionally high costs or exceptionally long lengths-of-stay. Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.07(3)(d) (attached as Exhibit 5).

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to acute hospitals for inpatient hospital services furnished to children greater than one year of age and less than six years of age if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923(a) of the Social Security Act. (See Federally-Mandated Disproportionate Share Adjustment, Section IV.D.2 for qualifying hospitals.) Hospitals will be reimbursed by the Division pursuant to the DHCFP Regulations at 114.1 CMR 36.07(3)(c) (attached as Exhibit 5).

13. **Emergency or Outpatient Department Visits which result in an Inpatient Admission**

Services provided to a recipient in an acute hospital outpatient or emergency department on the same day as an inpatient admission of that patient to the same hospital are reimbursed through the inpatient payment methodology only.

C. REIMBURSEMENT FOR UNIQUE CIRCUMSTANCES

1. Sole Community Hospital

The standard inpatient payment amount for a sole community hospital (as defined in Section II.RR) shall be equal to the sum of:

> 95% of the hospital's FY95 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY98 pass-through amount per discharge, direct medical education amount per discharge and the capital amount per discharge.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payer casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1996 through May 31, 1997.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, and an adjustment of 2.14% was made to reflect inflation between RY97 and RY98.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as sole community hospitals shall be determined by the Division.

2. Specialty Hospitals and Hospitals with Pediatric Specialty Units

The standard inpatient payment amount for specialty hospitals and hospitals with pediatric specialty units (as defined in Section II.II) shall be equal to the sum of:

> 95% of the hospital's FY95 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY98 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all-payer casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1996 through May 31, 1997.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97 and 2.14% to reflect inflation between RY97 and RY98.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as specialty hospitals and hospitals with pediatric specialty units shall be determined by the Division.

3. Public Service Hospital Providers

The standard inpatient payment amount for public service hospital providers (as defined in Section II.LL) shall be equal to the sum of:

95% of the hospital's FY95 cost per discharge, adjusted for casemix and inflation; and the hospital-specific RY98 pass-through amounts per discharge, direct medical education amount per discharge and the capital amount per discharge.

Adjustments were made for casemix by dividing the FY95 cost per discharge by the hospital's FY95 all payer casemix index and then multiplying the result by the hospital's Medicaid casemix index for the period June 1, 1996 through May 31, 1997.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, and 2.14% to reflect inflation between RY97 and RY98.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. **State-Owned Acute Teaching Hospitals**

a. Subject to Section IV.C.4.b, the inpatient payment amount for state-owned acute teaching hospitals' acute non-psychiatric admissions shall be equal to the hospital's RY98 cost per discharge calculated as follows:

FY95 total hospital-specific inpatient non-psychiatric charges are multiplied by the hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using FY95 RSC 403, Schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and Schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the FY95 hospital-specific non-psychiatric Medicaid discharges to the FY95 total hospital non-psychiatric discharges to yield the Medicaid inpatient non-psychiatric cost. The Medicaid inpatient non-psychiatric cost is then divided by the number of FY95 Medicaid non-psychiatric discharges to calculate the Medicaid cost per discharge. This Medicaid cost per discharge is multiplied by the inflation rate of 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, and 2.14% to reflect inflation between RY97 and RY98.

b. Any payment amount in excess of amounts which would otherwise be due any state-owned teaching hospital pursuant to Sections IV.B.2-6 and 8-9 is subject to specific legislative appropriation.

D. **Classification of Disproportionate Share Hospitals (DSHs) and Payment Adjustments**

MassHealth will assist hospitals that carry a disproportionate financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, MassHealth will make an additional payment to hospitals which qualify for such an adjustment under any one or more of the classifications listed below. Only hospitals that have an executed contract with the Division, pursuant to the RY98 RFA, are eligible for disproportionate share payments since the dollars are, in most cases, apportioned to the eligible group in relation to each other. MassHealth-participating hospitals may qualify for adjustments and may receive them at any time throughout the rate year. If a hospital's RFA contract is terminated, its adjustment shall be prorated for the portion of RY98 during which it had a contract with the Division. The remaining funds it would have received shall be apportioned to remaining eligible hospitals. The following describes how hospitals will qualify for each type of disproportionate share adjustment and the methodology for calculating those adjustments.

In accordance with federal and state law, hospitals must have a Medicaid inpatient utilization rate of at least 1% to be eligible for any type of DSH payment, pursuant to DHCFP regulation at 114.1 CMR 36.07 (9) (attached as Exhibit 6). Also, the total amount of DSH payment adjustments awarded to any hospital shall not exceed the costs incurred during the year of furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and by uninsured patients ("unreimbursed costs"), pursuant to 42 U.S.C. §1396r-4(g).

When a hospital applies to participate in MassHealth, its eligibility and the amount of its adjustment shall be determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications. Therefore, some disproportionate share adjustments may require recalculation pursuant to DHCFP regulations set forth at 114.1 CMR 36.07 (9) (attached as Exhibit 6). Hospitals will be informed if the adjustment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by the Division will be handled at that time.

To qualify for a DSH payment adjustment under any classification within Section IV.D., a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. §1396r-4(d) or qualify for the exemption described at 42 U.S.C. §1396r-4(d)(2).

1. **High Public Payer Hospitals: Sixty-Three Percent Hospitals**
(Total Annual Funding: $11,700,000)

The eligibility criteria and payment formula for this DSH classification are specified in DHCFP regulations at 114.1 CMR 36.09 (9)(a) (attached as Exhibit 6), and pursuant to its Interagency Service Agreement (ISA) with the Division. For purposes of this classification only, the term "disproportionate share hospital" refers to any acute hospital that exhibits a payer mix where a minimum of sixty-three percent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers and free care.

2. **Basic Federally-Mandated Disproportionate Share Adjustment**
(Total Annual Funding: $200,000)

The eligibility criteria and payment formula for this DSH classification are described in DHCFP regulations at 114.1 CMR 36.07 (9)(b) (attached as Exhibit 6) and in accordance with the minimum requirements of 42 U.S.C. §1396r-4.

3. **Disproportionate Share Adjustment for Safety Net Providers**

The eligibility criteria and payment formulas for this DSH classification are specified in DHCFP regulations at 114.1 CMR 36.07 (9)(c) (attached as Exhibit 6). Payments will be made by the Division to eligible hospitals in accordance with their agreements with the Division concerning intergovernmental transfer of funds.

4. **Uncompensated Care Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that incur "free care costs" as defined in DHCFP regulations at 114.1 CMR 7.00 (attached as Exhibit 7). The payment amounts for eligible hospitals participating in the free care pool are determined and paid by DHCFP in accordance with its regulations at 114.6 CMR 7.00.

5. **Public Health Substance Abuse Disproportionate Share Adjustment**

Hospitals eligible for this adjustment are those acute facilities that provide hospital services to low-income individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Public Health (DPH), in accordance with regulations set forth at 105 CMR 160.000 (attached as **Exhibit 8**), and DPH's ISA with the Division of Medical Assistance (Division). The payment amounts for eligible hospitals participating in the Public Health Substance Abuse program are determined and paid by DPH in accordance with regulations at 114.3 CMR 46.00 (attached as **Exhibit 8**) and DPH's ISA with the Division.

6. **Children's Medical Security Plan Disproportionate Share Adjustment**

Title XIX hospitals eligible for this adjustment are those that provide hospital services to low-income children (family of four earning $31,200 or less) who are uninsured, not enrolled in the MassHealth program and eligible for the Children's Medical Security Program, established by M.G.L. c. 111, § § 24F and 24G (attached as Exhibit 9). The payment amount for eligible hospitals receiving payments, pursuant to the Children's Medical Security Plan, are determined and paid on a periodic basis by the Department of Public Health under an interagency service agreement with the Division of Medical Assistance as the Title XIX single state agency, and in accordance with M.G.L. c.111 § § 24F and 24G.

E. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA).

If any portion of the reimbursement methodology is not approved by HCFA, the Division may recoup any payment made to a hospital in excess of the approved methodology.

F. Treatment of Reimbursement for Recipients in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, reimbursement to participating hospitals for services provided to MassHealth recipients who are at acute inpatient status prior to October 1, 1997 and who remain at acute inpatient status on or after October 1, 1997 shall continue to be reimbursed at the hospital's RY97 rates. Reimbursement to participating hospitals for services provided to Medicaid recipients who are admitted on or after October 1, 1997 shall be reimbursed at the RY98 hospital rates.

G. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

H. Errors in Calculation of Pass-through Amounts, Direct Medical Education Cost or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY98 pass-through costs, direct medical education costs or capital costs, resulting in an amount not consistent with the methodology, a correction can be made at any time during RY98, upon agreement by both parties. Such corrections will be made to the final hospital-specific rate retroactive to October 1, 1997 but will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs. Hospitals must submit copies of the relevant report as referenced in Section IV.B.1, highlighting items found to be in error, to Kiki Feldmar, Division of Medical Assistance, Benefit Services, 5th floor, 600 Washington Street, Boston, MA 02111 during the term of the contract to initiate a correction.

I. **New Hospitals**

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of this RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining hospitals' rates. Such rates may, in the Division's sole discretion, affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

J. **Hospital Change of Ownership**

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the hospital during the effective period of the RFA, the Division, in its sole discretion, shall determine, on a case by case basis (1) whether the hospital qualifies for reimbursement under this RFA, and, if so, (2) the appropriate rate of such reimbursement. The Division's determination shall be based on the totality of the circumstances. Any such rate may, in the Division's sole discretion, affect computation of the statewide average payment amount and / or any efficiency standard.

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INPATIENT ACUTE HOSPITAL

EXHIBIT 1: 130 CMR 415.415, 130 CMR 415.416

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

(1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.

(2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).

(3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.

(4) A recipient with lead poisoning is awaiting deleading of his or her residence.

(5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

(6)recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

(7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.

(8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:

(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies (respiratory, speech, physical, occupational, etc.);
(f) insertion, irrigation, and replacement of catheters; and
(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

(A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;

(B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or

(C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

415.417: Notification of Denial, Reconsideration, and Appeals

(A) Notification of Denial. The Division or its agent shall notify the recipient, the hospital, and the recipient's attending physician whenever it determines as part of a concurrent review that the hospital admission or stay, or any part thereof, is not medically or administratively necessary. The Division or its agent shall notify the hospital and the recipient's attending physician whenever it determines as part of a concurrent or retrospective review that the hospital stay is or was no longer medically necessary but is or was administratively necessary. The Division or its agent shall notify the hospital and the recipient whenever it determines as part of a concurrent review that a hospital stay is no longer administratively necessary due to the refusal of an appropriate placement.

(B) Reconsideration. An agent of the Division under 130 CMR 415.000 may provide an opportunity for reconsideration of a determination made by that agent. If a reconsideration is available, notice of the agent's determination will include written notice of: the right to a reconsideration; the time within and manner in which a reconsideration must be requested; and the time within which a decision will be rendered. A hospital, a physician, or a recipient entitled to have a determination reconsidered must request and have a reconsideration determination given before requesting a hearing under 130 CMR 415.417(C).

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EXHIBIT 2: Chapter 147 of the Acts of 1995, section 1

OFFICIAL

Chapter 147

Boston Public Health Act of 1995

AN ACT RELATIVE TO PUBLIC HEALTH IN THE CITY OF BOSTON.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Spec L c. 570 § 1

SECTION 1. (a) It is hereby declared for the benefit of the people of the city of Boston, in order that there be an increase in their welfare and an improvement in their living conditions, it is essential that a new public health care system be established for the city of Boston that can meet the challenges of a rapidly changing health care environment and ensure the continuous delivery of quality health care to the residents of the city; that the new public health care system must be able to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation, and long term care services in order to create a comprehensive and integrated continuum of care with the goal of promoting health and well-being, meeting the medical and public health needs of all served and of educating future physicians and caregivers; that a new public health commission be created in the city of Boston as the successor to the city's department of health and hospitals in order to better administer, enhance and expand the public health services provided by the city; and that the city's new public health care system should consist of a network of health care providers joining the city's traditional public health services and facilities with private hospitals, community health centers and other associated community based organizations and providers.

(b) It is hereby further declared for the benefit of the people of the city of Boston that the city should be empowered to provide for the establishment of a new medical center as the centerpiece of the city's public health network to be composed of Boston City Hospital, Boston Specialty and Rehabilitation Hospital and a private, nonprofit hospital; that the mission of the new medical center, in partnership with the city's public health commission, community health centers and other community based providers, shall be to consistently provide excellent and accessible health care services to all in need

of care, regardless of status or ability to pay; that recognizing the historic mission and commitment of Boston City Hospital to the public health needs of all residents of Boston, the new medical center shall have a continued commitment to the urban population, to vulnerable populations within the city, including those residents of the city who are underserved by existing health care services, and to other communities served; that the new medical center shall play an important role as a referral, tertiary level hospital serving the region in a financially responsible manner and continue to serve the most acutely ill patient populations; and that in the conduct of this mission, the new medical center shall commit itself to six equally important guiding principles: (1) ensuring the availability of a full range of primary through tertiary medical programs, in addition to a commitment to public health, preventive, emergency and long term rehabilitative care programs; (2) serving both urban and suburban communities in a culturally and linguistically competent manner that strives to meet the current and changing health care needs of people of all races, languages, cultures and economic classes; (3) providing a high degree of medical, nursing, management and technical competency and accountability; (4) enhancing its role as a major academic medical center, including support for bio-medical, public health, medical education and basic science research; (5) providing managed care services to the communities served by the new medical center and participating effectively and competitively in managed care plans serving the patient population; and (6) treating its patients, staff and the communities served with respect and dignity.

Spec L c. S70 § 1

This act may be referred to and cited as the Boston Public Health Act of 1995.

SECTION 2. As used in this act the following words shall, unless the context otherwise requires, have the following meanings:-

Spec L c. S70 § 2

"Board of health and hospitals", the board of health and hospitals of the city established pursuant to chapter six hundred and fifty-six of the acts of nineteen hundred and sixty-five.

"Boston City Hospital", the hospital located in the city provided for by chapter one hundred and thirteen of the acts of eighteen hundred and fifty-eight under the care and control of the department of health and hospitals, and all branches thereof heretofore or hereafter established, and all other

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INPATIENT ACUTE HOSPITAL

EXHIBIT 3: TRANSFER MATRICES

OFFICIAL

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

M : TRANSFERRING UNIT / TO: RECEIVING UNIT	MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE

SA NETWORK
PITAL

OFFICIAL

MH\SA NETWORK ITAL / TO: RECEIVING UNIT	MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
** PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

NON-MANAGED CARE RECIPIENT

MED SURG	** PSYCH	SUB\ABUSE
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

N CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN UNSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

TRANSFERRING RULES- WITHIN A HOSPITAL

MANAGED CARE RECIPIENT

(: TRANSFERRING UNIT / TO: RECEIVING UNIT	MED SURG	** PSYCH	SUB\ABUSE
MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH\SA CONTRACT RATE
** PSYCHIATRIC	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE
SUBSTANCE ABUSE	TRANSFERRING UNIT: MH\SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH\SA CONTRACT RATE

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PITAL

MH\SA NETWORK
PITAL

MED\SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
** PSYCHIATRIC	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE
SUBSTANCE ABUSE	TRANSFERRING UNIT:* NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING * & RECEIVING UNITS: NOT REIMBURSABLE

NON-MANAGED CARE RECIPIENT

MED SURG	** PSYCH	SUB\ABUSE
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

OFFICIAL

I CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN UBSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.